

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-a

CERTIFICATE OF DEATH

Reg. Dist. No. 2920

02016

1. PLACE OF DEATH: *Talbot*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
State Road
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Maryland* County.....*Talbot*
 City or town.....*Easton*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*State Road*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
NETTIE K. BEAVEN

3. (b) Social Security Number

4. Sex.....*Female* 5. Color or race.....*White* 6.(a) Single, married, widowed, or divorced.....*Widow*
 6.(b) Name of husband or wife.....*Rev. W. J. Beaven*
 7. Birth date of deceased (mo., day, yr.).....*December 9, 1863*
 6.(c) If alive, give age..... years
 8. AGE: Years.....*83* Months.....*2* Days.....*16* If less than one day..... hrs. min.

9. Birthplace.....*Talbot County, Md.*
 (Town, county, and state)

10. Usual occupation.....*Housewife*

11. Industry or business.....*Self Home*

12. Name.....*J. Thomas Kirby*

13. Birthplace.....*Md.*

14. Maiden name.....*Maggie Price*

15. Birthplace.....*Md.*

16. Informant.....*Mrs. Helen Beaven Feinby*

Address.....*Easton, Md.*

17. (Burial, cremation, or removal, Which?).....*Burial* Date thereof.....*Feb. 25, 1947*
 (month) (day) (year)

Cemetery or crematory.....*All Saints*

Location.....*Longwood, Md. (Rural)*

18. Funeral director.....*C. O. Clark*

Address.....*Easton, Md.*

19. *2/24* 19*47* *N. H. Neuman*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*February 22* 19*47*, at.....*M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 1 19*47* to *Feb 22* 19*47*
 and that I last saw him alive on *Feb 22* 19*47*

Immediate cause of death.....*Cerebral hemorrhage*

Other conditions.....*Arteriosclerosis*

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....*no*

Autopsy results.....*no*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; *no*

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....*D. M. C. Stevens M.D.*
 Address.....*Easton Md.* Date signed.....*2-24-47*

RECEIVED
FEB 28 1947
BUREAU V S.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 161-2

CERTIFICATE OF DEATH

Reg. Dist. No. 2900

1. PLACE OF DEATH:

County Denton
 City or town Denton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Eastern Memorial Hospital
 How long in hospital or institution? 15 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Caroline
 City or town Denton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Baby Boy Behlke

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Mother Mrs. Matilda Behlke
Denton, Md. 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb. 22, 1947
 8. AGE: Years 15 hrs Months _____ Days _____ If less than one day 15 hrs. min. _____

9. Birthplace Eastern Md.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business

FATHER 12. Name Charles Behlke
 13. Birthplace Anchorage, Alaska

MOTHER 14. Maiden name Matilda Heinel
 15. Birthplace Balto. Md.

16. Informant Memorial Hospital
 Address Eastern Md.

17. Burial Date thereof Feb 23, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Denton
 Location Denton, Maryland

18. Funeral director J. Virgil Moore & Son
 Address Denton, Maryland

19. 2/22/47 19 47 Registrar M. H. Harris
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 19 47 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22 19 47 to Feb 22 19 47 and that I last saw him alive on February 22 19 47

Immediate cause of death Uterine Tumor DURATION 15 hours

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Agnes Lederer M.D. M. D. or otherAddress 4200 Anne St. Date signed 2/23

RECEIVED

MAR 3 1947

BUREAU V S

2-38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02018

Reg. Dist. No.

2900

1. PLACE OF DEATH
County... Eastern
City or town... Easton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 da.
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 5 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County... Caroline
City or town... Marydel
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) if veteran, name war _____

3. (a) FULL NAME

Edith Brown

3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Robert Brown
6. (c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) Oct. 17, 1903
8. AGE: Years 43 Months 3 Days 17 If less than one day _____ hrs. _____ min.

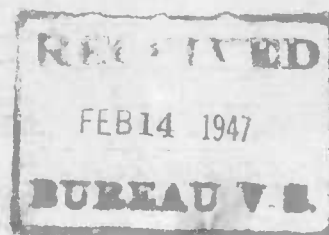
9. Birthplace Phila. Pa.
(Town, county, and state)
10. Usual occupation H. W.
11. Industry or business _____
12. Name Charles Woelford
13. Birthplace Md.
14. Maiden name Bertha K. Lion
15. Birthplace Md.

16. Informant Robert Brown
Address Marydel Md.
17. Burial Date thereof 2/6/47
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory Greensboro
Location Near Greensboro, Md.
18. Funeral director R. B. Pawlings
Address Greensboro, Md.
19. 2/8 19 47 N. H. Newlin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 19 47 at 10²⁵ a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 47
and that I last saw him alive on _____ 2 _____ 3 _____ 19 _____
Immediate cause of death Cardiac Embolism
Due to Atherosclerotic heart
Ex. piles
Due to Asthma
abdominal distention
Other conditions Hernia umbilical
strangulated.
(Include pregnancy within 3 months of death)
Major findings of operations See previous Transverse
Colon, Sigmoid Sigmoid
Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE un Palmer M. D. or other _____
Address Easton Md. Date signed _____



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2700

1. PLACE OF DEATH:

County TalbotCity or town Newcomb
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Ten year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Newcomb
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Orpha Wreata Burgess

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Earl C. Burgess7. Birth date of deceased (mo., day, yr.) Nov. 7 - 1883 6.(c) If alive, give age _____ years8. AGE: Years 63 Months 3 Days 21 If less than one day _____ hrs. _____ min.9. Birthplace Springport, Mich.
(City, town, county, and state)10. Usual occupation House wife

11. Industry or business _____

12. Name Charles Caruth13. Birthplace Michigan14. Maiden name Marion Gillette15. Birthplace Michigan16. Informant Earl C. BurgessAddress Newcomb Md17. Burial Date thereof March 3/1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Spring Hill CemeteryLocation Easton, Md.18. Funeral director John D. WilliamsAddress Easton, Md.19. 3/3 19 47 N. B. Nevin
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 19 47 at 6:53 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29 19 46 to February 28 19 47
and that I last saw him alive on February 28 19 47Immediate cause of death Arterial sclerosis
cerebral

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

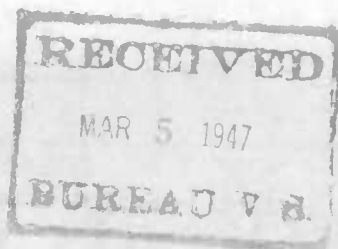
23. SIGNATURE R. B. Perkins M.D. M. D. or other _____Address Royal Oak, Md. Date signed 3/3

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-55-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information-carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 02020 2700

1. PLACE OF DEATH:

County... Talbot
 City or town... Easton Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 30 minutes
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution?... 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Caroline
 City or town... Denton, Md. RFD #3
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Baby Boy Elben

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb. 19, 1947

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. 30 min.9. Birthplace Easton, Talbot County, Md.

(Town, county, and state)

10. Usual occupation New born

11. Industry or business

MOTHER

12. Name

F. Cooper Elben

13. Birthplace

Caroline County

14. Maiden name

Evelyn Cranshaw

15. Birthplace

Queen Anne County

16. Informant

F. Cooper Elben

Address

Denton, Md. RFD #3

17.

(Burial, cremation, or removal. Which?)

Date thereof

2/25/47
(month) (day) (Year)

Cemetery or crematory

At home on farm

Location

Denton, Md.

18. Funeral director

Mr F Cooper Elben

Address

Denton, Md.

19.

2/19
(Date rec'd by registrar)19 47M. D. Neunig

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 19 47 at 3:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on 2-19- 19 47

Immediate cause of death

Premature Infant

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

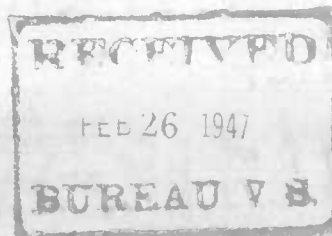
23. SIGNATURE

George White

M. D. or other

Address

Date signed



2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 03021
Reg. Dist. No. 8910

1. PLACE OF DEATH:

County Talbot
 City or town St Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 47 years
 Hospital, institution, or street address where death occurred:
Mulberry Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town St Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Mulberry Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Marion H. Gillis, Sr.

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mary Baynard Gillis
 6.(c) If alive, give age 65 years
 7. Birth date of deceased (mo., day, yr.) July 19, 1877.
 8. AGE: Years 69 Months 7 Days 7 If less than one day
 hrs. min.

9. Birthplace Salisbury, Md. Wicomico Co.
 (Town, county, and state)
 10. Usual occupation Ice Manufacturer
 11. Industry or business Ice Plant
 12. Name George Gillis
 13. Birthplace Salisbury, Md.
 14. Maiden name Eliza Jane Gillis
 15. Birthplace Wicomico Co., Md.

16. Informant Doctor Marion H. Gillis, Jr.,
 Address 204 Walnut St., Salisbury, Md.

17. Burial Date thereof March 1, 1947.
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Parsons
 Location Salisbury, Md.

18. Funeral director The Hill & Johnson Co.,
 Address Salisbury, Maryland.

19. Mar 3 1947 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1947. 19 at 10 PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
26 Feb. 19 47 to 26 Feb. 19 47
 and that I last saw him alive on 26 Feb. 19 47

Immediate cause of death Congestive Heart Failure 9302
 DURATION

Due to Cardiac disease 10 years
 9502

Due to
 Other conditions Asthma, chronic, bronchitis 112
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W. Herbert Morrison M. D.
 Address St Michaels, Md. Date signed Mar. 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 17 1947

BUREAU

RECEIVED

MAR 17 1947

BUREAU

2135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... Gallop
 City or town... Easton Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 hrs
 Hospital, institution, or street address where death occurred:
Easton Memorial Hosp.
 How long in hospital or institution? 4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Gallop
 City or town... Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Henry Thomas
Mr. Oswald Haddaway

3. (b) Social Security Number

216-14-2060

4. Sex M 5. Color or race W 6. (d) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. Van Haddaway7. Birth date of deceased (mo., day, yr.) Aug. 14, 1911

8. AGE: Years 35 Months 6 Days 9 If less than one day hrs. min.
 6. (c) If alive, give age 26 years

9. Birthplace Oxford Md
(Town, county, and state)10. Usual occupation Foreman11. Industry or business Poultry plant12. Name Julius Haddaway13. Birthplace Oxford, Md.14. Maiden name Redman Hill15. Birthplace Oxford, Md.16. Informant Mrs. O. H. T. HaddawayAddress Oxford, Md.17. Burial (Burial, cremation, or removal, Which?) Buried Date thereof 2/25/47
(month) (day) (year)Cemetery or crematory OxfordLocation Oxford Md18. Funeral director Marion E. HaddawayAddress Easton Md19. 2/24 19 47 N. H. Neeris
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Feb 19 47 at 10:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Feb 19 47 to 22 Feb 19 47
 and that I last saw him alive on 22 Feb 19 47
 Immediate cause of death Coronary thrombosis

Other conditions Obesity due to over food
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following;

Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Thomas Van Haddaway M.D.
M. D. or otherAddress 204 E. Rome St. Easton Date signed 22 Feb 47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 193

CERTIFICATE OF DEATH

Reg. Dist. No. 2000

1. PLACE OF DEATH:

County Talbot
 City or town Miles River RD#1
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

Miles River Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town Miles River
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Talbot Co. New Easton

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Anna Hinton

3. (b) Social Security Number

none4. Sex F 5. Color or race negro 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Chas. Hinton6.(c) If alive, give age deceased years7. Birth date of deceased (mo., day, yr.) 1890 - 7 - 1 (Jan 7)8. AGE: Years 57 Months 1 Days 0 It less than one day hrs. min.9. Birthplace Longwood Talbot Co. Md.
(Town, county, and state)10. Usual occupation Maid11. Industry or business -12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Geo. W. HintonAddress Preston Md.17. Burial Date thereof Feb. 11 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Copperville Md.Location Talbot Co.18. Funeral director Leon W. HenryAddress 310 South St. Easton Md.19. 2/11 47 W. H. Hinton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1947 at 6 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6 1947 to Feb. 7 1947and that I last saw her alive on Feb. 7 1947Immediate cause of death Acute Myocarditis DURATION 3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

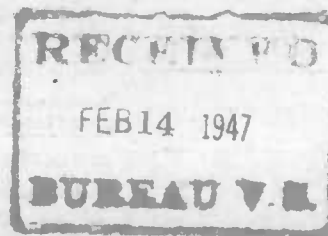
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Harward T. Webb, M.D. M. D. or otherAddress Easton, Md. Date signed 2/7/47



1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

CERTIFICATE OF DEATH

02024

Reg. Dist. No. 2900

1. PLACE OF DEATH:

County Talbot
 City or town Easton Md (Rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County TalbotCity or town Easton R.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

JOHN RICHARD HOPKINS

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) February 8, 18918. AGE: Years 66 Months 3 Days 3 If less than one day _____ hrs. _____ min.9. Birthplace Easton Talbot Co. Md R.D.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business _____

12. Name Clarence B. Hopkins13. Birthplace Wye Mills, Md Talbot Co.14. Maiden name Annie Wilkins15. Birthplace Kent County, Maryland16. Informant Miss Emily HopkinsAddress Easton Md.17. (Burial, cremation, or removal, Which?) Burial Date thereof Oct. 10, 1947
(month) (day) (year)Cemetery or crematory Wye Mills CemeteryLocation Wye Mills, Md.18. Funeral director Carl W. StaffordAddress Easton Md.19. 2/11 19 47 N.A. Nurus
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1947, at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Feb. 4 1947and that I last saw him alive on January 25 1947Immediate cause of death T.B. of the lungsDURATION Chrom.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Kurt Lederer M.D.Address Anne Arundel Md. Date signed 2/13

RECEIVED

19
FEB ~~IX~~ 1947

BUREAU V &

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

2159
2960

1. PLACE OF DEATH:

County.....*Prince Georges*
 City or town.....*Capitol Hill*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*Life*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*MD* County.....*Prince Georges*
 City or town.....*Capitol Hill*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*Washington*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary Jenkins

3. (b) Social Security Number

4. Sex.....*F* 5. Color of race.....*W* 6.(a) Single, married, widowed, or divorced.....*Single*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....*January 4, 1867*

6.(c) If alive, give age.....years

8. AGE: Years.....*85* Months.....*1* Days.....*22* If less than one day.....hrs.min.

9. Birthplace.....*Capitol Hill, Prince Georges, Maryland*
 (Town, county, and state)

10. Usual occupation.....*Housewife*

11. Industry or business.....

12. Name.....*Edwina Jenkins*13. Birthplace.....*Ind.*14. Maiden name.....*Elizabeth Dawson*15. Birthplace.....*Ind.*16. Informant.....*Mrs. Gail Mungar*Address.....*4000 Rockledge Washington DC*

17.....*Buried* Date thereof.....*Feb. 24, 1947*
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....*Spring Hill*Location.....*Capitol Hill, Prince Georges*18. Funeral director.....*Walter Clark*Address.....*Capitol Hill, Prince Georges*

19. *2/24* 19 *47* *M.D. Neeris*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Feb. 24* 19*47* at.....*330A* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*August 1st, 1946* to.....*Feb. 24, 1947*and that I last saw him/her alive on.....*Feb. 24, 1947*

Immediate cause of death.....*Epithelioma of the head of the*
pancreas DURATION.....*6 mo.*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*William S. Symons* M. D. or other

Address..... Date signed.....

RECEIVED

MAR 3 1947

BUREAU V.B.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 872

CERTIFICATE OF DEATH

Reg. Dist. No.

02025

2941

1. PLACE OF DEATH:

County Talbot
City or town Claiborne
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
City or town Claiborne
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Theodore J. Jones Jr.

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Melvena Jones

7. Birth date of deceased (mo., day, yr.)

Nov. 18 18726. (c) If alive, give age 72 years

8. AGE:

Years

74

Months

11

Days

12

If less than one day

hrs.

min.

9. Birthplace

Borman

(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

General Merchandise

MOTHER/FATHER

12. Name

Theodore J. Jones Sr.

13. Birthplace

Borman, Talbot Co. Ind.

14. Maiden name

Nancy Harrison

15. Birthplace

Borman, Talbot Co. Ind.

16. Informant

Olto Jones

Address

Claiborne, Ind.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 27, 1947

(month) (day) (year)

Cemetery or crematory

Family Burial Ground

Location

Borman Ind

18. Funeral director

Murman & Harrison

Address

St Michaels Ind

19. Feb. 26

(Date rec'd by registrar)

1947

Anna C. Thomas

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

25 February1947, at 8 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

23 February 1947, to 25 Feb. 1947and that I last saw him alive on 23 February 1947

Immediate cause of death

Dehydration

DURATION

and malnutrition

Due to

Parkinsonism8 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Herbert Morrison

M. D. or other

Address

St MichaelsDate signed 26 Feb. 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 6 1947

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2-25-

2-2940 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No. 2900

1. PLACE OF DEATH:

County Salbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death 3 hrs.
 Hospital, institution, or street address where death occurred: Easton Memorial Hosp.
 How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State PA. County
 City or town Phila.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5746 Harford Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Carrie Lee

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

7 B Singles

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1878
 6. (c) If alive, give age years

8. AGE: Years 69 Months 0 Days 6
 If less than one day hrs. min.

9. Birthplace Richmond, Va.
 (Town, county, and state)

10. Usual occupation Domestic - maid

11. Industry or business

12. Name unknown

13. Birthplace "

14. Maiden name unknown

15. Birthplace "

16. Informant Wm. H. Lee

Address 5746 Harford Ave. Phila 31, Pa.

17. Burial (Burial, cremation, or removal. Which?) Burial

Date thereof 2/26/47 (month) (day) (year)

Cemetery or crematory Eden Cemetery

Location Barley (Phila. Pa.)

18. Funeral director J. Edgar Black

Address Easton, Md.

2/24 19 47 N.H. Neenan

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23/47 19 47 at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death Myocardial failure

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carrie P. Neenan, M.D.

M. D. or other

Address Easton, Md.

Date signed 2-28-47

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FEB 28 1947
BUREAU V. S.

1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02027

2900

1. PLACE OF DEATH

County Talbot
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
How long above place of death? 35 yrs.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Harrison
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Harrison Leonard

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary E. Dawson

6. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1863

8. AGE: Years 83 Months 2 Days 22 If less than one day hrs. min.

9. Birthplace Trappe, Md.
(town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Thomas A. Leonard

13. Birthplace Trappe, Md.

14. Maiden name Olivia L. Parrott

15. Birthplace Baltimore, Md.

16. Informant Mrs. Florence Tarbitton

Address Easton, Md.

17. Burial Date thereof Feb. 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill Cemetery

Location Easton, Md.

18. Funeral director John D. Williams

Address Easton, Maryland

19. 2/26 1947 A. D. Henry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24th 1947 at 8:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6th to Feb. 24th

and that I last saw him alive on Feb. 24th

Immediate cause of death Carcinoma of the sigmoid

DURATION

10 mo.

Due to I.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William B. Seymour

M. D. or other

Address Easton Md Date signed 2-25-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 28 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 02028 2900

1. PLACE OF DEATH:

County Prince George's
 City or town Prince Charles Ind.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind. County Sacchar
 City or town Prince Charles
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) Is veteran, name war _____

3. (a) FULL NAME

Walter Willis Long

3. (b) Social Security Number

4. Sex Male 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Margie B. Long

7. Birth date of deceased (mo., day, yr.) Dec 20 1874 6. (c) If alive, give age 55 years

8. AGE: Years 77 Months ✓ Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Rochingham County, Va.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Thomas Long

13. Birthplace Va.

14. Maiden name Susan Landis

15. Birthplace Va.

16. Informant Mrs. W. W. Long

Address Prince George's Ind.

17. (Burial, cremation, or removal, Which?) Burial Date thereof March 1947
 (month) (day) (year)

Cemetery or crematory Spring Hill

Location Prince George's Ind.

18. Funeral director Walter Long

Address Prince George's Ind.

19. 2/28 19 47 N.B. Perkins
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 19 47 at 10.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 19 46 to 20 Feb 19 47

and that I last saw him alive on June 19 46

Immediate cause of death Cerebral accident

DURATION

Due to Hypertensive cardiovascular disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Phemba Harrison M.D.

M. D. or other _____

Address 204 E. Ave. St. Charles Date signed 27 Feb 47

RECEIVED
MAR 5 1947
BUREAU V &

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2900

1. PLACE OF DEATH:
 County Talbot
 City or town Easton Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 minutes
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State md County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war. _____

3. (a) FULL NAME
Marvel, Baby Boy

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced _____

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Feb 24, 1947 6. (c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. 15 min.

9. Birthplace Memorial Hospital
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Warner Marvel13. Birthplace Talbot County14. Maiden name Louise Harrington15. Birthplace Talbot Co.16. Informant Memorial HospitalAddress Easton Md.

17. Cremation Date thereof 3/4/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Memorial Hosp.Location Easton Md.18. Funeral director Memorial HospitalAddress Easton Md.

19. 314 19 47 N.H. Nevius
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 19 47 at 4 05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____, and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____
 Due to Asphyxia Neonatorum
Premature DURATION 3 mos

Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)
 Major findings of operations Retained placenta

Date of op. _____
 Autopsy results No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE N. D. Noble M. D. or other _____
 Address Easton Md Date signed 3/5/47

RECEIVED

MAR 11 1947

E. REAU V. G.

2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170

CERTIFICATE OF DEATH

Reg. Dist. No. 02030 2910

1. PLACE OF DEATH:

County Talbot
 City or town Newcomb
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 month
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State N.Y. County Astoria Long Island
 City or town 1423 - 30th Drive
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1423 - 30th Drive
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

John Arthur Mc Carthy

3. (b) Social Security Number

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced - w -

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 30, 1882 8.(c) If alive, give age 64 years8. AGE: Years 64 Months 8 Days 13 If less than one day hrs. min.9. Birthplace Florida (Town, county, and state)10. Usual occupation retired

11. Industry or business

12. Name John Mc Carthy13. Birthplace Ireland14. Maiden name unknown

15. Birthplace

16. Informant John D. Mc CarthyAddress Longhorne Pa.17. Burial Date thereof Feb 17, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Beechwood CemeteryLocation Hulmeville, Pa
Levnam & Harrison

18. Funeral director

Address St. Michaels Ind.19. Feb 18 1947 John Harwood
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1947, at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw h..... alive on19.....

Immediate cause of death..... DURATION

Acute alcoholism

Due to.....

Due to.....

Other conditions Partial gastrectomy
r-3yr deep -
 (Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Manner of injury..... Injured at work?

Louis J. Kelly MD Dep. Med. Dir.

23. SIGNATURE..... M.D. or other

Robert M. D. 2-13-47

Address..... Date signed.....

RECEIVED

MAR 6 1947

BUREAU V B.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02031

 ★ MV
 Reg. Dist. No. 2900

1. PLACE OF DEATH:

County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Hurlock (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ No ☒

3. (a) FULL NAME

Guy Franklin Molock

3. (b) Social Security Number

218-07-5999

4. Sex

male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

M. Marie Molock

7. Birth date of

deceased (mo., day, yr.)

May 30, 1910

B. (c) If alive, give age 32 years

8. AGE:

Years

Months

Days

If less than one day

36

8

9

hrs.

min.

9. Birthplace Dorchester County, Maryland

(Town, county, and state)

10. Usual occupation

Day Laborer

11. Industry or business Continental Can Company

FATHER

12. Name

Abraham L. Molock

13. Birthplace

Dorchester County, Maryland

MOTHER

14. Maiden name

Susie Martin

15. Birthplace

Kent County, Maryland

18. Informant

Mrs. M. Marie Molock

Address

Hurlock, Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 12, 1947
(month) (day) (year)

Cemetery or crematory

Washington Cemetery

Location

Near Hurlock, Maryland

18. Funeral director

J. J. Frampton and Son

Address

Federalburg, Maryland

19.

(Date rec'd by registrar)

2/12/47

N. W. Neenan

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1947 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

X

19

to

X

19

and that I last saw h. X alive on X 19

Immediate cause of death

Fracture at Base of Skull

DURATION

1 day

Due to

Due to

Other conditions

Fractures of both legs

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Feb. 9/47Where did injury occur? Hurlock Dorchester Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) N. Main St.Means of injury AutomobileInjured at work? no

23. SIGNATURE

J. K. Shriver - Dep. Med. Exam

M. D. or other

Address Cambridge, Md.Date signed Feb. 9/47

RECEIVED

FEB 14 1947

BUREAU V. N.

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12201

CERTIFICATE OF DEATH

Reg. Dist. No. 12032 2900

1. PLACE OF DEATH:

County... Talbot County
 City or town... Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 hours
 Hospital, institution, or street address where death occurred:
 Memorial Hospital
 How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Talbot
 City or town... Trappe
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) if veteran, name war.....

3.(a) FULL NAME

Ann
 Alice Nixon

3.(b) Social Security Number

4. Sex F 5. Color or race B 6.(a) Single, married, widowed, or divorced W

6.(b) Name of husband or wife Albert Nixon

7. Birth date of deceased (mo., day, yr.) May 10, 1860 6.(c) If alive, give age years

8. AGE: Years 86 Months 80 Days 14 If less than one day hrs. min.

9. Birthplace Havre de Grace Md (Town, county, and state)

10. Usual occupation H.W.

11. Industry or business

12. Name Solomon Banks

13. Birthplace Havre de Grace Md

14. Maiden name Unknown

15. Birthplace "

16. Informant Leon W. Henry

Address Easton Md

17. Burial, cremation, or removal. Which? Burial Date thereof Mar 12 47 (month) (day) (year)

Cemetery or crematory Cemetery

Location Trappe Md

18. Funeral director Leon W. Henry

Address Easton Md

19. 2/28 19 47 N.H. Neeris (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 19 47 at 2:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-26-47 19 to 2-27 19 47 and that I last saw her alive on 2-26-47 19

Immediate cause of death Shock DURATION 6 hours

Due to Vascular Collapse 8 hrs

Due to Strangulated Femoral Hernia left

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Strangulated femoral Hernia left - released Date of op 2-26-47

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.T.B. Ambler MD M. D. or other

Address Easton Md Date signed 2-27-47

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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

02035

290C

1. PLACE OF DEATH: County <u>Tulsa</u> City or town <u>Edmond</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 days</u> Hospital, institution or street address where death occurred: <u>Edmond Memorial Hospital</u> How long in hospital or institution? <u>2 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Dorchester</u> City or town <u>Harlock</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____	
3. (a) FULL NAME <u>Mrs. Mary Osbourne</u>		3. (b) Social Security Number _____	
4. Sex <u>F</u>	5. Color or race <u>W</u>	6. (u) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife <u>Arthur Osbourne</u>		6. (c) If alive, give age _____ years	
7. Birth date of deceased (mo., day, yr.) <u>1898</u>			
8. AGE: Years <u>49</u>	Months	Days	If less than one day _____. hrs. _____. min.
9. Birthplace <u>md</u> (Town, county, and state)			
10. Usual occupation <u>H. W.</u>			
11. Industry or business _____			
FATHER	12. Name <u>Joseph Andrews</u>		
	13. Birthplace <u>Harlock md.</u>		
MOTHER	14. Maiden name <u>Mary Todd</u>		
	15. Birthplace <u>md.</u>		
16. Informant <u>Arthur Osbourne</u> Address <u>Harlock</u>			
17. Burial <u>Burial</u> Date thereof <u>Feb 28 1947</u> (Burial, cremation, or removal? Which?) (month) (day) (year) Cemetery or crematory <u>Cemetery</u> <u>Harlock</u> Location <u>F.B. Willoughby</u>			
18. Funeral director <u>Harlock</u> Address _____			
19. <u>2/26</u> 19 <u>47</u> <u>N.H. Merwin</u> (Date rec'd by registrar) Registrar			
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Feb 25</u> 19 <u>47</u> at <u>3:55 P.</u> M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Feb. 10</u> 19 <u>47</u> to <u>Feb 25</u> 19 <u>47</u> and that I last saw him <u>ev</u> alive on <u>Feb 25</u> 19 <u>47</u> Immediate cause of death <u>Coronary Thrombosis.</u> DURATION <u>immediate</u> Due to <u>Broncho Pneumonia left</u> <u>1 day</u> Due to <u>Septic Coma -</u> <u>10 hr</u> Other conditions <u>Colon Bacillus infection</u> <u>8 yrs.</u> <u>left kidney.</u> (Include pregnancy within 3 months of death) Major findings of operations _____ Date of op. _____ Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____ 23. SIGNATURE <u>W.E. Lannon MD</u> M. D. or other <u>Fidwashington</u> Address _____ Date signed <u>2/27/47</u>			

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02034

2900

1. PLACE OF DEATH

County FrederickCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County FrederickCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex M.5. Color or race W.6.(a) Single, married, widowed, or divorced Widower6.(b) Name of husband or wife Anna Silverman7. Birth date of deceased (mo., day, yr.) July 4, 1870

6.(c) If alive, give age _____ years

8. AGE: Years 76 Months 6 Days 5 If less than one day _____ hrs. _____ min.9. Birthplace Poland
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Mary Silverman13. Birthplace Poland14. Maiden name Joseph Robert15. Birthplace Poland16. Informant A. C. SilvermanAddress Easton - Md.17. Reburial Date thereof Feb 10, 1947
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Washville N.C.Location Washville, N.C.18. Funeral director Reitz BankAddress Easton - Md.19. 2/9 47 N.H. Meeres
(Date) (cc day registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1947 at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 1946, to February 8 1947and that I last saw him alive on Feb. 8 1947

Immediate cause of death _____ DURATION _____

Carcinoma of Endometrium yr.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter F. Buell M.D. M. D. or other _____Address Easton, Maryland Date signed 2-10-47

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age is shown on

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

02035

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH

County Tablet

City or town Easton Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Easton Memorial Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Tablet

City or town Tablet
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr George B Stewart

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

B. (b) Name of husband or wife Mrs Evelyn Stewart

7. Birth date of deceased (mo., day, yr.) Aug 1 1871

6. (c) If alive, give age _____ years

8. AGE: Years 71 Months 7 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Druggist

11. Industry or business drugs business

12. Name Joseph Stewart

13. Birthplace Maryland

14. Maiden name Marlette Lague

15. Birthplace Maryland

16. Informant Mrs Stewart

Address Hillsboro, Maryland

17. Burial Date thereof 8/5/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillsboro

Location Hillsboro Md.

18. Funeral director R. B. Rawlings

Address Greensboro, Md.

19. 2/3 47 N.Y. Neer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 19 47 at 10 12 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 Jan 19 47 to 2 Feb 19 47

and that I last saw in alive on 2 Feb 19 47

Immediate cause of death Cardiac failure due to myocardial infarction due to hypertensive arterio-sclerotic heart disease

DURATION 4 weeks

Due to _____

Other conditions Diabetes mellitus

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Thos L. Harrison M.D.

Address 214 E. Rowe St. Capitol Heights, Md. Date signed Feb 27 47

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13120

CERTIFICATE OF DEATH

Reg. Dist. No. 2900

1. PLACE OF DEATH:

County SalisburyCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 days

Hospital, institution or street address where death occurred:

Eastern Memorial Hosp.How long in hospital or institution? 15 days

3. (a) FULL NAME

Randolph Thomas

4. Sex

M

5. Color or race

B. P

6. (a) Single, married, widowed, or divorced

MarriedB. (b) Name of husband or wife Fannie Thomas7. Birth date of deceased (mo., day, yr.) unknown 18646. (c) If alive, give age 45 years8. AGE: Years 83 Months Days If less than one day
.....hrs.min.9. Birthplace Norfolk Va.
(Town, county, and state)10. Usual occupation none Laborer11. Industry or business Cannery12. Name Unknown13. Birthplace "14. Maiden name Unknown15. Birthplace "18. Informant Annie ThomasAddress Hillsboro Md.17. Burial Date thereof 2/12/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium GreenmountLocation Hillsboro, Md.18. Funeral director Garrett GildAddress Easton Md.19. 2/11 47 N. H. Meirus
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Salisbury Co.City or town Queen Anne
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 19 47 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 7 19 45 to Feb 9 19 45and that I last saw him alive on Feb 9 19 45Immediate cause of death uremia

DURATION

Due to hypertrophied prostateDue to arteriosclerosisOther conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

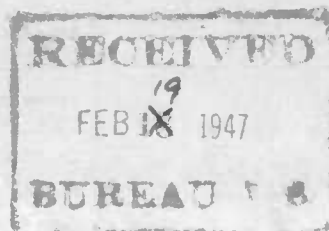
Accident, suicide, or homicide. Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. F. Schneider, M.D.Address Easton Md. Date signed Feb 10, 1947



2-35